GREAT WESTERN INSURANCE COMPANY

Great Western Final Expense Insurance

SALES KIT BOOKLET

AGENT INSTRUCTIONS

Please complete the following:

☐ Application for Final Expense Insurance Policy

☐ Bank Draft Information

☐ Additional forms which may be required. See forms marked Complete and Send with Application. All other forms should be left with the applicant.

Submit applications electronically by MyEnroller, Mail or Fax.

MyEnroller
Electronic Application Submission Tool
Website: my.gwic.com/online

Mail
Great Western Insurance Company
P.O. Box 14410
Des Moines, IA 50306-3410

Fax
515-247-2500

If you have any questions, please call 866-252-5594.

43 130 1000 050120 OK

GREAT WESTERN INSURANCE COMPANY

Application for Individual Life Insurance

❒ New coverage ❒ Reinstatement of policy # _____

Agent number: _____

P.O. Box 14410, Des Moines, IA 50306-3410
Fax: 515-247-2500 • Phone: 1-800-733-5454
Email: FENEW@GWIC.COM • Website: www.gwic.com

Part A: Proposed Insured *(Full legal name)*

Full name of applicant - *first name, M.I., last, suffix* | Date of birth *(MM/DD/YYYY)* | Gender

Address | City | State | ZIP code

Phone number | Email address | Social Security number

Part B: Owner *(Complete only if other than proposed insured)*

Full name of owner - *first name, M.I., last, suffix* | Date of birth *(MM/DD/YYYY)* | Gender

Address | City | State | ZIP code

Phone number | Email address | Relationship to insured | Social Security number

Part C: Policy Information

If all of the questions in Part D can be answered "NO," then the proposed insured is eligible for a Level Death Benefit. If one or more of the health questions are answered "YES," are not answered, or it is determined during the underwriting process they should have been answered "YES," then the policy will be issued with a Graded Death Benefit.

❒ Level Death Benefit ❒ Graded Death Benefit Requested effective date: _____

Face amount: $_____ Ultimate Death Benefit: $_____

For Level Death Benefit, multiply face amount by 125% to determine the Ultimate Death Benefit.

Payment mode: ❒ Monthly ❒ Quarterly ❒ Semiannually ❒ Annually Base premium amount: $_____

❒ Dependent child/Grandchild rider *(complete separate application)*
$5,000 face amount on base policy is required Rider premium amount: $_____

Total premium amount: $_____

Part D: Medical Information *(Do not complete if applying for Guaranteed Assurance - Graded Death Benefit)*

1. In the last 24 months have you been confined to a bed, received hospice care, been in a hospital or a nursing home for 5 or more days in total? ❒ Yes ❒ No

2. Do you require assistance or supervision to perform routine daily activities such as bathing, dressing, eating, toileting, or transferring to or from a bed or chair? ❒ Yes ❒ No

3. In the past 24 months have you consulted a member of the medical profession, been treated for, been diagnosed with or taken medication for any of the following:
   - diabetes requiring insulin, with complications, or requiring 3 or more medications;
   - internal cancer, malignant melanoma, leukemia, Hodgkin's Disease, or lymphoma;
   - heart surgery including bypass, angioplasty or stent placement, congestive heart failure, heart attack, stroke, peripheral vascular disease, or aneurysm;
   - emphysema, chronic obstructive pulmonary disease (COPD), or oxygen use;
   - a neuromuscular disease, Amyotrophic Lateral Sclerosis (ALS), Parkinson's, or Multiple Sclerosis;
   - kidney failure or dialysis;
   - liver disease such as chronic hepatitis or cirrhosis;
   - dementia, Alzheimer's disease, or schizophrenia;
   - alcohol or drug abuse; or
   - organ transplant?

   ❒ Yes ❒ No

4. a. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ❒ Yes ❒ No
   b. In the last 24 months have you received treatment from a member of the medical profession for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?
   ❒ Yes ❒ No

Part D: Medical Information - continued

Please provide the name and phone number of your Primary Care Physician (required for Level Death Benefit):

Primary Care Physician's name | Phone number

Part E: Beneficiary

Primary (*full legal name)* | Relationship to insured | Phone number

Address | City | State | ZIP code

Contingent (*full legal name)* | Relationship to insured | Phone number

Address | City | State | ZIP code

Part F: Application Agreement

By signing below, I agree: (1) I represent statements in this application are complete and true. (2) When the policy is delivered, the insured must be alive and in the same health as described above or there will be no insurance. (3) The full premium for the chosen mode must be paid by the time the policy is delivered. (4) By keeping the policy past the free look period, my written consent is hereby given to any change(s), correction(s), or addition(s) that have been made to the policy for which I am applying.

Authorization: I authorize any healthcare provider, medical facility, pharmacy benefit manager or other pharmacy related services organization, health plan, insurance company, MIB, Inc., claims administrator, government agency, or other person or firm, to disclose to Great Western Insurance Company (GWIC) or its authorized representative, any records or information it needs about the insured's health, including copies of records concerning physical or mental illness, advice, diagnosis, prognosis, prescription information, care or treatment provided to the insured. I understand that such information will be used by GWIC for the purpose of evaluating my application for insurance. A copy of this approval will be as effective as the original. Health information obtained will not be redisclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. I authorize GWIC, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. I understand that I or any authorized representative will receive a copy of this authorization upon request. This approval is valid for twenty-four (24) months from the date signed. This time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. This authorization may be revoked by me in writing, which I may do at any time by contacting GWIC.

I affirm that no illustration was used in the sale of this product.

FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Do you have any existing insurance policies or annuity contracts? ❒ Yes ❒ No

Will the insurance applied for replace or change any insurance or annuity that is now or has recently been in force? *If "Yes," complete required replacement form(s).* ❒ Yes ❒ No

X

Proposed insured's signature | Date *(MM/DD/YYYY)*

X

Owner's signature *(If other than proposed insured)* | Date *(MM/DD/YYYY)*

Part G: Agent Certification

I certify that the answers from the proposed insured to Part D were recorded accurately.

Does the applicant have any existing insurance policies or annuity contracts? ❒ Yes ❒ No

Will the insurance applied for replace or change any insurance or annuity that is now or has recently been in force? ❒ Yes ❒ No

X

Agent full name *(please print)* | Agent number

X

Agent's signature | Date *(MM/DD/YYYY)*

GREAT WESTERN INSURANCE COMPANY

P.O. Box 14410 Des Moines, IA 50306-3410
Fax: 515-247-2500 • Phone: 1-800-733-5454
Email: FENEW@GWIC.COM • Website: www.gwic.com

Child/Grandchild Protection Plan

State_____ *(Print)* Agent Name_____ Agent Number_____ Date_____

Insured's Information

First Name	Middle Initial	Last Name		
Street Address	City		ST	Zip
Phone #	Date of Birth (mm/dd/yyy)		Social Security #	
Sex: ☐Male ☐Female	Email Address			

Child / Grandchild Protection Rider Information

Existing Policy #	Rider Premium $1.00 per month

Does the applicant have any existing policy or annuity? ☐YES ☐NO

Will the proposed insurance replace any existing policy or annuity? ☐YES ☐NO

If yes, please complete a replacement form

Conditions of Child / Grandchild Protection Plan

I apply for the Child / Grandchild Protection Plan and understand that only the Covered Child / Grandchild(ren) who are listed below and who meet the following conditions will be covered.

- The Covered Child / Grandchild is living with a parent, grandparent, or guardian at the time of death and has never married.
- The Covered Child / Grandchild is at least one year of age and has not attained the age of eighteen (18) years.
- The Covered Child / Grandchild dies while the Insured on the base Policy is alive.
- The coverage under the base Policy to which this Rider is attached is active and current in its premium payments.

Child/Grandchild's Full Name	Date of Birth	Child/Grandchild's Full Name	Date of Birth

Agreement

Agree by signing below, I agree that (1) to the best of my knowledge and belief, statements in this Application are complete and true. (2) When the Policy is delivered, the Applicant and listed child / grandchild(ren) must be alive. Also, the full premium must be paid by the time the Policy is delivered. (3) By keeping the Policy past the free look period, my written consent is hereby given to any change(s), correction(s), or addition(s) that GWIC may make to the Policy for which I am applying.

X _____ Signed on _____ Signed at _____
Insured's Signature (mm/dd/yyyy) (City, State)

X _____
Owner's Signature *(If other than the Proposed Insured)*

X _____
Agent's Signature

For the Agent: Is replacement of insurance involved? ☐Yes ☐No

To the Applicant: You should hear from the Company within sixty days of the application date. If you don't, state the facts of your application in a letter to the Secretary of the Great Western Insurance Company at the address listed above.

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P.O. Box 14410
Des Moines, IA 50306-3410
Fax: 515-247-2500
Phone: 1-800-733-5454
www.gwic.com

Notice Regarding Replacement

NOTICE TO APPLICANTS REGARDING REPLACEMENT OF LIFE INSURANCE OR AN ANNUITY

THIS NOTICE IS FOR YOUR BENEFIT AND IS REQUIRED BY OKLAHOMA LAW

1. If you are urged to purchase life insurance and to surrender, lapse or in any other way change the status of existing life insurance, the agent is required to give you this notice.

2. It may not be advantageous to drop or change existing life insurance in favor of new life insurance, whether issued by the same or a different insurance company. Some of the disadvantages are:

   a) The amount of the annual premium under an existing policy may be lower than that under a new policy having the same or similar benefits.

   b) Generally, the initial cost of life insurance policies are charged against the cash value increases in the earlier policy years; the replacement of an old policy could result in the policyholder sustaining the burden of these costs twice.

   c) The incontestable and suicide clauses begin anew in a new policy. This could result in a claim under a new policy being denied by the company, which would have been paid under the old policy.

   d) Existing policies may have more favorable provisions than new policies in such areas as settlement options and disability benefits.

   e) An existing policy may have a reserve value in addition to any cash value, which may be of some benefit to the insured.

   f) The insurance company carrying your current insurance policy can often make a desired change on terms, which would be more favorable than if existing insurance is replaced with new insurance.

3. It may not be advantageous to change an existing policy to reduce paid-up or extended term insurance or to borrow against its loan value beyond your expected ability or intention to repay in order to obtain funds for premiums on a new policy.

4. There may be a situation in which a replacement policy is advantageous. You may want to receive the comments of the present insurance company before deciding this important financial matter.

List of Policies or Contracts to be Replaced:

	Company Name	Name of Insured	Policy/Contract No.
1.			
2.			
3.			
4.			

I hereby acknowledge that I received the above "Notice to Applicants Regarding Replacement of Life Insurance or an Annuity" before I signed the application for the proposed new insurance.

X _____ _____

Applicant's Signature | Date

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X _____ _____

Applicant’s Signature — Date

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Life Replacement Advertising

AGENT'S STATEMENT

I,_____ have complied with the following in connection with the replacement sales transaction:

a. I have used only company approved sales advertising.

b. I have given a copy of all sales advertising used during the presentation to the applicant, including printed copies of any electronically presented sales materials.

X _____
Agent Signature

_____
Agent Number

_____
Date

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Notice Regarding Replacement

STATEMENT BY APPLICANT REGARDING NOTIFICATION OF REPLACEMENT TO THE REPLACED INSURER

I have read the "NOTICE TO APPLICANTS REGARDING REPLACEMENT OF LIFE INSURANCE OR AN ANNUITY," which was furnished to me by the agent taking the application for this policy.

1. Please notify my present insurer(s) regarding this transaction.

X _____ _____
Applicant's Signature Date

2. Please do not notify my present insurer(s) regarding this transaction.

X _____ _____
Applicant's Signature Date

This signature of the applicant shall be that of the insured unless someone other than the insured is the owner of the policy. If someone other than the insured is the owner of the policy, the owner must sign. If the insured is under eighteen (18) years of age, the parent is deemed to be the owner of the policy.

CERTIFICATION BY THE AGENT:

I hereby certify that nothing was said or done during the sales presentation to influence the decision of the applicant regarding this statement.

X _____ _____ _____
Agent's Signature Insurance Agency or Agent License Number Date

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Information on the Accelerated Death Benefit Rider

INCLUSION OF RIDER
If you qualify for a Level Death Benefit policy, your policy will automatically include the Accelerated Death Benefit Rider at no additional charge. You qualify for the Level Death Benefit by answering "No" to the health questions on the application and providing your primary care physician's information.

DESCRIPTION OF RIDER
Great Western Insurance Company will pay an Accelerated Death Benefit to the Owner upon proof the insured has a Qualifying Medical Condition. Payment is subject to the terms and conditions of the Policy and this Rider while the Policy and this rider remain in force.

QUALIFYING MEDICAL CONDITION
Qualifying Medical Condition means either: 1.) Terminal Illness - You are terminally ill. You are expected to die within 12 months. Or 2.) Chronic Illness - You cannot perform two Activities of Daily Living for a period of at least 90 days. Or you have permanent severe cognitive impairment and similar forms of dementia requiring substantial supervision.

EFFECT OF RECEIPT OF BENEFITS
The application and receipt of an Accelerated Death Benefit will terminate your policy. You will not receive any additional death benefit on the death of the insured. The policy will not have any cash value after receipt of the Accelerated Death Benefit. You will not be required to pay additional premiums for the policy after receipt of the Accelerated Death Benefit. Any loan on the policy at the time of receipt of Accelerated Death Benefit will be paid off by the benefit before you receive the Accelerated Death Benefit and you will not be able to take future loans from the policy.

BENEFIT
The Accelerated Death Benefit paid to you may be reduced by an administrative charge and interest charges.

TAXES AND GOVERNMENT ASSISTANCE
This Accelerated Death Benefit may be taxable. We have not intended for this Accelerated Death Benefit to qualify for favorable tax treatment. Prior to electing to receive the Accelerated Death Benefit, you should seek assistance from a qualified tax adviser.

Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs, such as Medicaid. Prior to electing to receive the Accelerated Death Benefit, you should consult with the appropriate social services agency concerning how receipt of Accelerated Death Benefits may affect that eligibility.

USE OF PROCEEDS
This benefit will not restrict your use of proceeds. The benefits provided by this Accelerated Death Benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance.

ADDITIONAL INFORMATION
When you receive your policy, you will receive the Accelerated Death Benefit Rider form which will explain the benefits and conditions of this option fully.

There is no charge for this rider, and you may choose not to apply for Accelerated Death Benefits even if you have a Qualifying Medical Condition.

X _____	X _____	_____
Applicant's Signature	Agent's Signature	Date

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BENEFIT
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TAXES AND GOVERNMENT ASSISTANCE
This Accelerated Death Benefit may be taxable. We have not intended for this Accelerated Death Benefit to qualify for favorable tax treatment. Prior to electing to receive the Accelerated Death Benefit, you should seek assistance from a qualified tax adviser.

Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs, such as Medicaid. Prior to electing to receive the Accelerated Death Benefit, you should consult with the appropriate social services agency concerning how receipt of Accelerated Death Benefits may affect that eligibility.

USE OF PROCEEDS
This benefit will not restrict your use of proceeds. The benefits provided by this Accelerated Death Benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance.

ADDITIONAL INFORMATION
When you receive your policy, you will receive the Accelerated Death Benefit Rider form which will explain the benefits and conditions of this option fully.

There is no charge for this rider, and you may choose not to apply for Accelerated Death Benefits even if you have a Qualifying Medical Condition.

X _____	X _____	_____
Applicant's Signature	Agent's Signature	Date

BANK DRAFT INFORMATION

Complete this form only if you selected the automatic bank withdrawal payment option.

Ongoing premium - ***Authorization to bank or other financial institution***

☐ Checking ☐ Savings Requested withdrawal date (1st - 28th only) _____

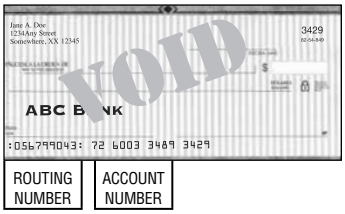
First name (as it appears on account) | M.I. | Last name (as it appears on account)

Billing address | City | State | ZIP code

Bank or financial institution name (including branch, if any) | Routing number

Bank or financial institution's address | Account number

Please read: By providing my account information here and signing this form, I authorize the bank whose name and address I am providing to pay and to charge to my account the amount of any check, instrument, or any other funds made by and payable to Great Western Insurance Company (the "Company") for insurance premiums. I authorize the Company to contact my bank or financial institution on my behalf for the sole purpose of obtaining information necessary to administer my preauthorized withdrawals in conjunction with my insurance coverage. This authorization is to remain in effect until revoked by me in writing. Until you receive and have reasonable time to act on such notices, you shall be fully protected in accepting any preauthorized withdrawal against my account.



Account holder's signature _____ Date _____

Note: Enrollments using a credit or debit card for premium payments must be submitted electronically. Paper applications cannot contain credit or debit card information.

GREAT WESTERN INSURANCE COMPANY

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Receipt for Initial Premium

Final Expense Receipt

I, the listed agent below, have received an application from _____
(Applicant's Name)

for a Final Expense Whole Life Insurance policy with the following rider:

❒ Dependent Child / Grandchild Rider

Face amount of Life Insurance applied for: $ _____.

Amount of initial premium received by agent: $ _____.

This receipt is given and accepted for an application for insurance. This insurance will not be in force until the policy is issued and the first premium is paid in full.

If your application cannot be approved, we will promptly refund your money. ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

If you do not hear from our company within 30 days, please contact us by one of the following methods:

Write to:
Great Western Insurance Company
PO Box 14410 • Des Moines, IA 50306-3410

Call:
Customer Care at 1-800-733-5454

_____ _____
Agent's Signature Date

_____
Agent's Printed Name

GWIC® GREAT WESTERN INSURANCE COMPANY

Guaranteed Assurance Rate Chart

Per Unit Face Annual Premiums		
Age	**Male**	**Female**
40	56	45
41	57	46
42	59	48
43	61	50
44	62	51
45	63	52
46	64	53
47	65	54
48	67	55
49	67	56
50	68	56
51	69	57
52	69	59
53	70	60
54	72	62
55	74	64
56	76	67
57	79	69
58	81	71
59	84	73

Per Unit Face Annual Premiums		
Age	**Male**	**Female**
60	87	76
61	91	79
62	94	82
63	98	86
64	102	90
65	107	93
66	113	97
67	119	101
68	125	105
69	132	111
70	140	119
71	149	128
72	159	139
73	170	150
74	178	156
75	187	163
76	197	171
77	208	180
78	220	190
79	242	207
80	270	225

Take Face Amount, divide by $1,000;
Multiply by Annual Premium;
Add $35.00 Policy Fee;
Divide by:

- **2** for Semi-Annual Premium
- **4** for Quarterly Premium
- **12** for Monthly Premium

Example:
46 Year Old Female;
Face Amount $15,000; Monthly

$15,000/1,000 = $15.00
$15.00 x 53 = $795.00
$795.00 + $35.00 = $830.00
$830.00/12 = $69.17 Monthly Premium

GWIC® GREAT WESTERN INSURANCE COMPANY

Dear Policyholder:

Great Western is the provider of your insurance policy. We appreciate your business and value our relationship with you.

As part of that relationship, be assured that we respect your personal privacy. We don't sell information. Furthermore, we don't share any information regarding our customers with anyone outside of Great Western, other than policy beneficiaries, assignees or agents.

Federal law requires banks, investment and insurance companies to notify their customers annually, of their official Privacy Policy. We encourage you to read our formal Privacy Policy printed below.

It is our pleasure to serve you and we sincerely appreciate your business.

Sincerely,

Thomas A. Swank, President

Privacy Policy

Great Western's Customer Commitment Includes
Respect for Your Personal Privacy

Great Western has a long-standing commitment to our customer's personal privacy. Any information we collect relates only to our business with you.

Nonpublic Personal Information
In the course of processing and maintaining your insurance policy, Great Western may collect nonpublic personal information about you from your application and other forms, from your transactions with us, and from our agents or affiliates. This information includes name, address, Social Security Number, and beneficiary designations.

Nondisclosure of Nonpublic Personal Information
We do not give or sell any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

Restricted Access to Nonpublic Personal Information
Furthermore, we restrict access to nonpublic personal information about you to only those employees who need to know that information in order to provide products or services to you.

Nondisclosure of Personal Health or Medical Information
We do not give or sell personal health or medical information about you, except as permitted by law or upon your written authorization.

Safeguard Nonpublic Personal Information
We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

Be assured that we respect your privacy and that we will continue to secure the information that you have entrusted to us.

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Email: FENEW@GWIC.COM • Website: www.gwic.com

Child/Grandchild Protection Plan

State_____ *(Print)* Agent Name_____ Agent Number_____ Date_____

Insured's Information

First Name	Middle Initial	Last Name		
Street Address	City		ST	Zip
Phone #	Date of Birth (mm/dd/yyy)		Social Security #	
Sex: ☐Male ☐Female	Email Address			

Child / Grandchild Protection Rider Information

Existing Policy #	Rider Premium $1.00 per month

Does the applicant have any existing policy or annuity? ☐YES ☐NO

Will the proposed insurance replace any existing policy or annuity? ☐YES ☐NO

If yes, please complete a replacement form

Conditions of Child / Grandchild Protection Plan

I apply for the Child / Grandchild Protection Plan and understand that only the Covered Child / Grandchild(ren) who are listed below and who meet the following conditions will be covered.

- The Covered Child / Grandchild is living with a parent, grandparent, or guardian at the time of death and has never married.
- The Covered Child / Grandchild is at least one year of age and has not attained the age of eighteen (18) years.
- The Covered Child / Grandchild dies while the Insured on the base Policy is alive.
- The coverage under the base Policy to which this Rider is attached is active and current in its premium payments.

Child/Grandchild's Full Name	Date of Birth	Child/Grandchild's Full Name	Date of Birth

Agreement

Agree by signing below, I agree that (1) to the best of my knowledge and belief, statements in this Application are complete and true. (2) When the Policy is delivered, the Applicant and listed child / grandchild(ren) must be alive. Also, the full premium must be paid by the time the Policy is delivered. (3) By keeping the Policy past the free look period, my written consent is hereby given to any change(s), correction(s), or addition(s) that GWIC may make to the Policy for which I am applying.

X _____ Signed on _____ Signed at _____
Insured's Signature (mm/dd/yyyy) (City, State)

X _____
Owner's Signature *(If other than the Proposed Insured)*

X _____
Agent's Signature

For the Agent: Is replacement of insurance involved? ☐Yes ☐No

To the Applicant: You should hear from the Company within sixty days of the application date. If you don't, state the facts of your application in a letter to the Secretary of the Great Western Insurance Company at the address listed above.